Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $8,171.97 for date of service 03/21/01.
   b. The request was received on 03/08/02.

II. EXHIBITS

1. Requestor:
   a. TWCC 60 and Letter Requesting Medical Dispute dated 06/25/02
   b. UB-92
   c. TWCC 62/Medical Audit
   d. Medical reports
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC-60 Response to a Request for Dispute Resolution dated 07/12/02
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/01/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/01/02. The response from the insurance carrier was received in the Division on 07/15/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/25/02:
"(Requestor) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. Specifically, this determination of fair and reasonable rate is based upon contractual agreements with the majority of Workers' Compensation Carriers and payments of 85% of 'usual and customary' charges made by other Workers' Compensation and Commercial insurance companies."

2. Respondent: letter dated 07/12/02;
"…(Carrier)'s payment is consistent with the fair and reasonable criteria in section 413.011(b) of the Texas Labor Code. (Carrier) used data from two national resources: 1) ASC charges as listed by CPT code in '1994 ASC Medicare Payment Rate Survey,' and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code….SOAH has concluded (Carrier)'s methodology meets the statutory standards of the Labor code and in fact its method does result in a fair and reasonable payment."

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only date of service eligible for review is 03/21/01.

2. Per the TWCC-60, the provider billed a total of $8,907.77 on the date of service in dispute.

3. Per the TWCC-60, the carrier reimbursed the provider $680.80 for the date of service in dispute.

4. The amount in dispute per the TWCC-60 is $8,171.97.

5. The EOB denial code is, "M – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM." The medical audit dated 05/24/01 states, "…the payment …has been determined to be fair and reasonable…"

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401(a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011(b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. Regardless of the carrier's methodology or lack thereof, or a timely or untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Based on the evidence available for review, the provider did not meet the criteria of Rule 413.011 (b) or 133.307 (g) (3) (D) and did not prove that the carrier's reimbursement is not fair and reasonable. Therefore, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 14th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm